BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
Richard Dieter Ruth, M.D.	)	Case No. 800-2015-015077
Physician's and Surgeon's Certificate No. A 85653	)	
Respondent	)	

DECISION

The attached Stipulated Settlement and Disciplinary Order is hereby adopted as the Decision and Order of the Medical Board of California, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on February 8, 2019.

IT IS SO ORDERED: January 11, 2019.

MEDICAL BOARD OF CALIFORNIA

Kristina Lawson, J.D., Chair
Panel B

XAVIER BECERRA
Attorney General of California
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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD DIETER RUTH, M.D.** **8291 San Pablo Drive** **Buena Park, CA 90620** **Physician's and Surgeon's Certificate No. A85653** Respondent.	Case No. 800-2015-015077 OAH No. 2018081130 **STIPULATED SETTLEMENT AND DISCIPLINARY ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Kimberly Kirchmeyer (Complainant) is the Executive Director of the Medical Board of California (Board). She brought this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Martin W. Hagan, Deputy Attorney General.

2. Respondent Richard Dieter Ruth, M.D. (Respondent) is represented in this proceeding by Thomas M. O'Neil, Esq., of Bonne Bridges Mueller O'Keefe & Nicholls, whose address is 355 South Grand Avenue, Suite 1750, Los Angeles, California 90071.

3. On or about January 9, 2004, the Board issued Physician's and Surgeon's Certificate No. A85653 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 800-2015-015077, and will expire on December 31, 2019, unless renewed.

JURISDICTION

4. On July 6, 2018, Accusation No. 800-2015-015077 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 6, 2018. Respondent timely filed his Notice of Defense contesting the Accusation. A true and correct copy of Accusation No. 800-2015-015077 is attached as Exhibit A and incorporated herein by reference as if fully set forth herein.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 800-2015-015077. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

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CULPABILITY

8. Respondent agrees that, at an administrative hearing, Complainant could establish a *prima facie* case with respect to the charges and allegations in Accusation No. 800-2015-015077, and that he has thereby subjected his Physician's and Surgeon's Certificate No. A85653 to disciplinary action. Respondent further agrees to be bound by the Board's imposition of discipline as set forth in the Disciplinary Order below.

9. Respondent further agrees that if he ever petitions for early termination or modification of probation, or if an accusation and/or petition for revocation of probation is filed against him before the Board, all of the charges and allegations contained in Accusation No. 800-2015-015077 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving Respondent in the State of California or elsewhere.

10. Respondent agrees that his Physician's and Surgeon's Certificate No. A85653 is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

CONTINGENCY

11. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

12. The parties agree that this Stipulated Settlement and Disciplinary Order shall be null and void and not binding upon the parties unless approved and adopted by the Board, except for this paragraph, which shall remain in full force and effect. Respondent fully understands and

agrees that in deciding whether or not to approve and adopt this Stipulated Settlement and Disciplinary Order, the Board may receive oral and written communications from its staff and/or the Attorney General's Office. Communications pursuant to this paragraph shall not disqualify the Board, any member thereof, and/or any other person from future participation in this or any other matter affecting or involving respondent. In the event that the Board does not, in its discretion, approve and adopt this Stipulated Settlement and Disciplinary Order, with the exception of this paragraph, it shall not become effective, shall be of no evidentiary value whatsoever, and shall not be relied upon or introduced in any disciplinary action by either party hereto. Respondent further agrees that should this Stipulated Settlement and Disciplinary Order be rejected for any reason by the Board, respondent will assert no claim that the Board, or any member thereof, was prejudiced by its/his/her review, discussion and/or consideration of this Stipulated Settlement and Disciplinary Order or of any matter or matters related hereto.

ADDITIONAL PROVISIONS

13. This Stipulated Settlement and Disciplinary Order is intended by the parties herein to be an integrated writing representing the complete, final and exclusive embodiment of the agreements of the parties in the above-entitled matter.

14. The parties agree that copies of this Stipulated Settlement and Disciplinary Order, including copies of the signatures of the parties, may be used in lieu of original documents and signatures and, further, that such copies shall have the same force and effect as originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree the Board may, without further notice to or opportunity to be heard by respondent, issue and enter the following Disciplinary Order:

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DISCIPLINARY ORDER

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. A85653 issued to Respondent Richard Dieter Ruth, M.D. is revoked. However, the revocation is stayed and Respondent is placed on probation for five (5) years on the following terms and conditions.

1. **CONTROLLED SUBSTANCES - TOTAL RESTRICTION**. Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If Respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, Respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, Respondent shall inform the patient or the patient's primary caregiver that Respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on Respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits Respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

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2. **EDUCATION COURSE**. Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 25 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 50 hours of CME of which 25 hours were in satisfaction of this condition.

3. **PRESCRIBING PRACTICES COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

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4. **MEDICAL RECORD KEEPING COURSE**. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping approved in advance by the Board or its designee. Respondent shall provide the approved course provider with any information and documents that the approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision. Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

5. **MONITORING - PRACTICE**. Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Board or its designee for prior approval as a practice monitor, the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed

statement that the monitor has read the Decision(s) and Accusation(s), fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine and whether Respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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In lieu of a monitor, Respondent may participate in a professional enhancement program approved in advance by the Board or its designee that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

6. **SOLO PRACTICE PROHIBITION**. Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) Respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) Respondent is the sole physician practitioner at that location.

If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the Respondent's practice setting changes and the Respondent is no longer practicing in a setting in compliance with this Decision, the Respondent shall notify the Board or its designee within five (5) calendar days of the practice setting change. If Respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume practice until an appropriate practice setting is established.

7. **PROHIBITED PRACTICE**. During probation, Respondent is prohibited from practicing, performing, or treating any patients in the area of pain management, which shall be defined as utilizing pharmacological approaches to prevent, reduce, or eliminate pain of a recurrent or chronic nature. After the effective date of this Decision, all patients being treated by the Respondent shall be notified that the Respondent is prohibited from practicing, performing, or

treating any patients in the area of pain management, which shall be defined as utilizing pharmacological approaches to prevent, reduce, or eliminate pain of a recurrent or chronic nature. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; 2) patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

8. **NOTIFICATION**. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

9. **SUPERVISION OF PHYSICIAN ASSISTANTS AND ADVANCED PRACTICE NURSES**. During probation, Respondent is prohibited from supervising physician assistants and advanced practice nurses.

10. **OBEY ALL LAWS**. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

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11. **QUARTERLY DECLARATIONS**. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

12. **GENERAL PROBATION REQUIREMENTS**.

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit.

Address Changes: Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice: Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days. In the event Respondent should leave the State of California to reside or to practice, Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

13. **INTERVIEW WITH THE BOARD OR ITS DESIGNEE**. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

14. **NON-PRACTICE WHILE ON PROBATION**. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is

defined as any period of time Respondent is not practicing medicine as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If Respondent resides in California and is considered to be in non-practice, Respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve Respondent from complying with all the terms and conditions of probation. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete the Federation of State Medical Boards's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice for a Respondent residing outside of California will relieve Respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

15. **COMPLETION OF PROBATION**. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

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16. **VIOLATION OF PROBATION**. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

17. **LICENSE SURRENDER**. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

18. **PROBATION MONITORING COSTS**. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

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ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, Thomas M. O'Neil, Esq. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate No. A85653. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Medical Board of California.

DATED: 11/9/18

RICHARD DIETER RUTH, M.D.
Respondent

I have read and fully discussed with Respondent Richard Dieter Ruth, M.D., the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: 11.9.2018

THOMAS M. O'NEIL, ESQ.
Attorney for Respondent

ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California.

Dated: 11/9/2018

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
MATTHEW M. DAVIS
Supervising Deputy Attorney General

MARTIN W. HAGAN
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 800-2015-015077

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Attorneys for Complainant

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **RICHARD DIETER RUTH, M.D.** **8291 San Pablo Drive** **Buena Park, California 90620** **Physician's and Surgeon's Certificate No. A 85653,** Respondent.	Case No. 800-2015-015077 ACCUSATION

Complainant alleges:

PARTIES

1. Kimberly Kirchmeyer (complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California, Department of Consumer Affairs (Board).

2. On or about January 9, 2004, the Board issued Physician's and Surgeon's Certificate No. A 85653 to Richard Dieter Ruth, M.D. (respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges and allegations brought herein and will expire on December 31, 2019, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 2227 of the Code states:

"(a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

"(1) Have his or her license revoked upon order of the board.

"(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

"(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

"(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

"(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

"(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences, professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1."

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5. Section 2234 of the Code, states:

"The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

". . .

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

". . ."

6. Section 2266 of the Code states:

"The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

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FIRST CAUSE FOR DISCIPLINE

(Gross Negligence)

7. Respondent is subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (b), of the Code, in that he committed gross negligence in his care and treatment of patients A, B, C, and D, as more particularly alleged hereinafter:

8. On or about February 2008, respondent, who completed a residency in internal medicine, opened his solo practice. According to respondent, approximately ninety percent (90%) of his patients were seen for pain management. Respondent did not have any advanced training in pain management, and according to respondent, his pain management training was limited to a four month stint he did as part of his residency, in which he treated addicts and was exposed to "treatment and rehab." According to respondent, officials from the Drug Enforcement Administration (DEA) made a visit to his house on May 17, 2017, and advised him that he was under investigation. Respondent claims he was told that he could resolve the investigation against him by surrendering his DEA certificate, which he decided to do. Respondent then closed his solo practice.

PATIENT A

9. According to respondent's certified medical records, respondent first started treating patient A,[1] a then-50-year old male, on or about September 4, 2012. Patient A's documented history of present illness (HPI) included prior lumbar compression fracture, pain since 1998, intermittently taking hydrocodone-acetaminophen (APAP) (Vicodin) for pain, and not interested in surgical intervention. Physical examination included normal vital signs and pain at L4-S1 with flexion and extension with a normal neurological exam. The documented assessment and plan was "pain management" start hydrocodone-acetaminophen (APAP) (Norco)[2] (#120) q 4 (every 4

[1] Patient A is being used in place of the patient's name or initials to maintain patient confidentiality. The other patients in this Accusation are referred to patients B, C, and D, to also maintain their confidentiality.

[2] Hydrocodone APAP (Vicodin®, Lortab® and Norco®) is a hydrocodone combination of hydrocodone bitartrate and acetaminophen which was formerly a Schedule III controlled substance pursuant to Health and Safety Code section 11056, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022. On August 22, 2014, the DEA (continued...)

hours) as needed for pain with tramadol (Ultram)[3] (#90) 2 tablets b.i.d. (twice a day) for breakthrough pain with a notation of discussing risks and benefits with patient and return to clinic as needed. The medical records contain a "Medication Use Agreement" that was signed and dated by respondent on September 4, 2012, but not signed by patient A. At the completion of the visit, patient A was provided with prescriptions for Norco and tramadol (Ultram) as set forth in the assessment and plan.

10. During the period of on or about September 5, 2012, to December 31, 2012, respondent had three office visits with patient A. According to respondent's progress notes, the visits took place on September 27, October 16, and December 13, 2012. Respondent's progress notes set forth a narrative that remained the same for every visit and for each of the other patients discussed herein. Specifically, the repeating narrative stated:

> "Patient returned to clinic for regular Pain Management visit. Pain controlled on current prescriptions. Denies any side effects. Reports no new complaints. Continue on same treatment."

The repeating narrative was then, for the most part, followed by a perfunctory "A/P" [assessment and plan] which merely stated "Pain Management" followed by the controlled substances that were being prescribed followed by "Patient will return [time indicated] for continue (sic) of treatment." Those progress notes that were handwritten were generally in the same format but used abbreviations for some of the repeating verbiage. Respondent's progress

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(...continued)
published a final rule rescheduling hydrocodone combination products (HCP's) to Schedule II of the Controlled Substances Act, which became effective October 6, 2014. Schedule II controlled substances are substances that have a currently accepted medical use in the United States, but also have a high potential for abuse, and the abuse of which may lead to severe psychological or physical dependence. When properly prescribed and indicated, HCP's are used for the treatment of moderate to severe pain. In addition to the potential for psychological and physical dependence there is also the risk of acute liver failure which has resulted in a black box warning being issued by the Federal Drug Administration (FDA). The FDA black box warning provides that "[a]cetaminophen has been associated with cases of acute liver failure, at times resulting in liver transplant and death. Most of the cases of liver injury are associated with use of the acetaminophen at doses that exceed 4000 milligrams per day, and often involve more than one acetaminophen containing product."

[3] Tramadol (Ultram®), an opioid analgesic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain.

notes were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2012, respondent issued four prescriptions, some of which were post-dated,[4] for hydrocodone/APAP (Norco) 10/325 mg (#120) every four hours as needed; and two prescriptions of tramadol (Ultram) 50 mg (#90) 2 tablets b.i.d. (twice a day).

11. During the period of on or about January 1, 2013, to December 31, 2013, respondent had eight office visits with patient A. According to respondent's progress notes, the visits took place on February 25, May 28, July 16, August 8, September 3, October 29, November 25, and December 19, 2013. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2013, respondent issued approximately eighteen (18) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#120) (every four hours) and twenty-eight (28) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) 1 to 2 tablets b.i.d. (twice a day). During 2013, patient A also filled six (6) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (approximate total of 750 tablets) that were prescribed by another physician, Dr. Q.A., that respondent was unaware of because he was not utilizing risk screening measures, including

[4] At his subject interview before a Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU) Investigator, respondent indicated that he would provide post-dated prescriptions to some of his patients that he "trusted" and that he knew "were coming from a far distance, and it would be a burden for them to come see me."

but not limited to, periodically reviewing California's Controlled Substances Utilization and Evaluation System (CURES).[5]

12. During the period of on or about January 1, 2014, to December 31, 2014, respondent had ten office visits with patient A. According to respondent's progress notes, the visits took place on March 13, March 31, April 29, June 10, July 16, August 11, September 15, October 13, November 12, and December 22, 2014. On December 22, 2014, respondent issued a prescription (with one refill) for Ambien 10 mg (#30) with no adequate explanation of why it was being prescribed and with no consideration of the risks associated with the concomitant use of Ambien and the opioids that were being prescribed. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2014, respondent issued approximately twenty-seven (27) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#120) (every four hours); at least thirty-nine (39) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); and approximately thirteen (13) prescriptions for oxycodone/APAP (Percocet)[6] (every six hours), [initially seven prescriptions of #20 beginning on June 10 and then six prescriptions of #30

[5] Filling prescriptions from another person was a violation of the "Medication Use Agreement" which provided, in part, that "I understand that the medication will be prescribed only by Dr. Ruth and only according to the agreed upon schedule…I will not seek or obtain any medications for pain other than those prescribed by my doctor…I accept the right of my doctor's medical staff to terminate this agreement for any of the following reasons: [1] I seek or obtain any pain medications from a source other than my doctor…" As mentioned, patient A did not sign the agreement contained within respondent's certified medical records.

[6] 19. Percocet® (oxycodone and acetaminophen), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of moderate to moderately severe pain. The DEA has identified oxycodone, as a drug of abuse. (Drugs of Abuse, A DEA Resource Guide (2011 Edition), at p. 41.) The Federal Drug Administration has issued a black box warning (continued…)

beginning on October 13, 2014][7] and one prescription of zolpidem tartrate (Ambien)[8] 10 mg (#30) q.h.s. (before sleep). During 2014, patient A was also filling prescriptions for other controlled substances, hydrocodone/APAP (Norco) 10/325 mg (approximate total of 1,770 tablets), tramadol (Ultram) 50 mg (approximate total of 540 tablets) and carisoprodol (Soma)[9] 350 mg (approximate total of 90 tablets) prescribed by another physician, and being filled at different pharmacies, which respondent was unaware of because he was not utilizing risk screening measures, including but not limited to, periodically reviewing CURES.

13. During the period of on or about January 1, 2015, to December 31, 2015, respondent had nine office visits with patient A. According to respondent's progress notes, the visits took place on February 2, March 4, March 26, May 7, August 13, September 1, October 8, November 9, and December 17, 2015. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent,

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for Percocet® which warns about, among other things, addiction, abuse and misuse, and the possibility of "life-threatening respiratory distress."

[7] Respondent's progress notes of November 12 and December 22, 2014, incorrectly indicate "Percocet 10/325 #20" when the actual prescriptions indicate respondent wrote prescriptions for Percocet 10/325 mg (#30).

[8] Zolpidem tartrate (Ambien®), a centrally acting hypnotic-sedative, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the short-term treatment of insomnia characterized by difficulties with sleep initiation.

[9] Soma® (carisoprodol) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of acute and painful musculoskeletal conditions. According to the DEA, Office of Diversion Control, "[c]arisoprodol abuse has escalated in the last decade in the United States...According to Diversion Drug Trends, published by the DEA on the trends in diversion of controlled and noncontrolled pharmaceuticals, carisoprodol continues to be one of the most commonly diverted drugs. Diversion and abuse of carisoprodol is prevalent throughout the country. As of March 2011, street prices for [carisoprodol] Soma® ranged from $1 to $5 per tablet. Diversion methods include doctor shopping for the purposes of obtaining multiple prescriptions and forging prescriptions."

proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2015, respondent issued approximately eighteen (18) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#120) (every four hours); twenty-two (22) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); seven (7) prescriptions for oxycodone/APAP (Percocet) (#30) (every six hours) [respondent's progress notes incorrectly indicate #20]; ten (10) prescriptions for oxycodone/APAP (Percocet) (#60) (every six hours) [with no indication in the progress notes why the amount was increased from #30 to #60 beginning on May 7, 2015]; and fourteen (10) prescription of zolpidem tartrate (Ambien) 10 mg (#30) q.h.s. (before sleep). During 2015, patient A was also filling prescriptions for other controlled substances, hydrocodone/APAP (Norco) 10/325 mg (approximate total of 180 tablets) and tramadol (Ultram) 50 mg (approximate total of 630 tablets) prescribed by another physician, and being filled at different pharmacies, which respondent was unaware of because he was not utilizing risk screening measures, including, but not limited to, periodically reviewing CURES.

14. During the period of on or about January 1, 2016, to December 31, 2016, respondent had fourteen office visits with patient A. According to respondent's progress notes, the visits took place on January 4, January 22, February 14, March 28, April 11, May 4, June 14, July 5, July 25, August 30, October 5, November 2, November 23, and December 19, 2016. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2016, respondent issued approximately nine (9) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#120) (every four hours); six

(6) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#100) (every four hours) [beginning on July 25, 2016]; fifteen (15) prescriptions for oxycodone/APAP (Percocet) (#60) (every six hours); sixteen (16) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); and twenty-one (21) prescriptions (which includes refills) of zolpidem tartrate (Ambien) 10 mg (#30) q.h.s. (before sleep).

15. During the period of on or about January 1, 2017, to May 17, 2017, respondent had five office visits with patient A. According to respondent's progress notes, the visits took place on January 12, February 6, March 6, April 5, and May 1, 2017. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of time in 2017, respondent issued approximately five (5) prescriptions for hydrocodone/APAP (Norco) 10/325 mg (#100) (every four hours); five (5) prescriptions for oxycodone/APAP (Percocet) (#60) (every six hours); five (5) prescriptions for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); and five (5) prescriptions (which includes refills) of zolpidem tartrate (Ambien) 10 mg (#30) q.h.s. (before sleep).

16. Respondent committed gross negligence in his care and treatment of patient A which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed controlled substances to patient A without, among other things, obtaining vital signs, considering less risky therapies, conducting appropriate and focused physical examinations, assessing underlying or coexisting conditions, following a treatment plan with measurable stated objectives in regard to pain level and function, conducting meaningful periodic review, seeking consultation, when necessary, and utilizing risk screening measures to identify aberrant

behavior and possible diversion of the controlled substances that were being prescribed; and

(b) Respondent failed to maintain complete and adequate medical records concerning his care and treatment of patient A. Respondent's progress notes, among other things, were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed.

PATIENT B

17. According to respondent's certified medical records, respondent first started treating patient B, a then-52-year old female, on or about December 9, 2015. patient B was Patient A's wife. Patient B's self-reported chief complaint was lower back pain that she began experiencing in July 2013, which she attributed to climbing a ladder and retrieving merchandise at the retail store where she worked. Patient B's documented past medical history was positive for diabetes, emotional difficulty, irregular heart beat, and alleged lower back pain. Contained within patient B's medical records was a "Panel Qualified Medical Evaluation" (QME) from mid-2015, in regard to a workers' compensation claim, which gave a diagnostic impression of "lumbosacral spine musculoligamentous strain/sprain" with a recommendation that patient B "should be provided future office visits, oral medication, bracing, and up to 24 therapy sessions for conservative treatment of her lumbar spine." According to the QME, patient B did "not present with findings consistent with radiculopathy and there was no evidence of neural compression or displacement on the MRI study." Respondent documented a HPI of (1) bilateral hip pain; (2) lower back pain; (3) diabetes; and (4) weight control issues. Respondent did not do any follow up

in regard to Patient B's reported "emotional difficulty" and claimed "she was dealing with it with her PMD [primary medical doctor]," although that was not documented by respondent. Respondent conducted a physical examination and noted, among other things, full range of motion in the neck area with minor pain; positive flexion pain for the right hip and some back pain at L4-L5. No vital signs were recorded. Patient B's height and weight were reported as 5' 3" and 130 pounds. Respondent's assessment and plan was "pain management" with hydrocodone/APAP (Norco) (#120) every four hours (20-day supply) and tramadol (Ultram) 50 mg (#90) p.r.n.; phentermine[10] 37.5 mg (#30) for weight loss; and follow up with primary care physician in regard to her diabetes.

18. During the period of on or about January 1, 2016, to December 31, 2016, respondent had eight (8) office visits with patient B. According to respondent's progress notes, the visits took place on January 12, February 3, March 28, April 11, May 3, May 24, June 22, and August 30, 2016. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2016, respondent issued approximately seven (7) prescriptions of hydrocodone/APAP (Norco) (#120) (every four hours); eight (8) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); and fifteen prescriptions (which includes refills) for phentermine 37.5 mg (#30) (one per day). During 2016, patient B also filled two (2) prescriptions

[10] Phentermine HCL (Lonamin®, Fastin®, Adipex®), an anorectic, is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (f), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated phentermine HCL is used as a short term adjunct in a regiment of weight reduction based on exercise, behavioral modification, and caloric restriction. According to the DEA fact sheet for anorectic drugs, phentermine can produce amphetamine-like effects and is frequently encountered on the illicit market.

for tramadol (Ultram)50 mg (#90) that were prescribed by another physician, Dr. Q.A.[11], that respondent was unaware of because he was not utilizing risk screening measures, including but not limited to, periodically reviewing CURES.

19. During the period of on or about January 1, 2017, to March 13, 2017, respondent had three (3) office visits with patient B. According to respondent's progress notes, the visits took place on January 16, February 14, and March 13, 2017. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of time, respondent issued approximately three (3) prescriptions of hydrocodone/APAP (Norco) (#120) (every four hours); six (6) prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) t.i.d. (three a day); and six (6) prescriptions (which includes refills) for phentermine 37.5 mg (#30) (one per day).

20. Respondent committed gross negligence in his care and treatment of patient B which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed controlled substances to patient B without, among other things, obtaining vital signs, considering less risky therapies, conducting appropriate and focused physical examinations, assessing underlying or coexisting conditions, following a treatment plan with measurable stated objectives in regard to pain level and function, conducting meaningful periodic review, seeking consultation, when necessary, and utilizing risk screening measures to identify aberrant

[11] Patient A, who was patient B's husband, was also obtaining prescriptions for various controlled substances from Dr. Q.A., while he was receiving prescriptions from respondent.

behavior and possible diversion of the controlled substances that were being prescribed; and

(b) Respondent failed to maintain complete and adequate medical records concerning his care and treatment of patient B. Respondent's progress notes, among other things, were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed.

PATIENT C

21. According to respondent's certified medical records, respondent first started treating patient C, a then-38-year old female, on or about June 16, 2011.[12] Patient C's self-reported chief complaint was "pain on entire side of left body" which she attributed to a neck injury in 2009 that allegedly occurred while she "was coaching a cross country team and hit a tree." Patient C claimed that she had surgery approximately eighteen months prior, with no details as to what kind of surgery. Patient C filled out a review of systems form in which she reported, among other things, neck pain, neck stiffness, stiff joints, "muscles hurt," and frequent headaches. According to respondent's chart notes for this visit, patient C was on pain meds and wanted a new physician to manage her alleged pain. Respondent performed a physical examination which he claims indicated, among other things, neck and cervical spine pain with full range of motion. Respondent's assessment and plan was (1) positive cervical pain (with patient willing to consider physical therapy); (2) prescribe hydrocodone/APAP (Norco) (#120) q 4 (every 4 hours), and

[12] Conduct occurring more than seven (7) years from the filing date of this Accusation is for informational purposes only and is not alleged as a basis for disciplinary action.

carisoprodol (Soma) 350 mg (#90) one tab t.i.d. (three times a day); and (3) return to clinic p.r.n. (as needed).

22. During the period of on or about June 17, 2011, to December 31, 2011, respondent had seven (7) office visits with patient C. According to respondent's progress notes, the visits took place on June 30, July 14, August 4, August 24, September 7, October 15, November 22, 2011. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of time, respondent issued approximately ten (10) prescriptions, some of which were post-dated, for hydrocodone/APAP (Norco) (#120) (every four hours); five prescriptions for carisoprodol (Soma) 350 mg (#90) t.i.d. (three times a day) and zolpidem tartrate (Ambien) 10 mg (#30) q.h.s. (before sleep).

23. During the period of on or about January 1, 2012, to December 31, 2012, respondent had five (5) office visits with patient C. According to respondent's progress notes, the visits took place on January 31, April 17, July 2, September 12, and December 13, 2012. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2012, respondent issued approximately

fourteen (14) prescriptions[13] for hydrocodone/APAP (Norco) (#120) (every four hours); seven (7) prescriptions (which includes refills) for carisoprodol (Soma) 350 mg (#90) t.i.d. (three a day); and six (6) prescriptions (which includes refills) for tramadol (Ultram).

24. During the period of on or about January 1, 2013, to December 31, 2013, respondent had two (2) office visits with patient C. According to respondent's progress notes, the visits took place on July 1 and December 23, 2013. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2013, respondent issued approximately seven prescriptions[14] for hydrocodone/APAP (Norco) (#120) (every four hours); two (2) prescriptions (which includes refills) for carisoprodol (Soma) 350 mg (#90) t.i.d. (three a day); six (6) prescriptions (which includes refills) for escitalopram (Lexapro) (a SSRI that is generally used to treat major depressive disorder and generalized anxiety disorder) 20 mg (#30) [with no detailed description of why the Lexapro (with five refills) was being prescribed in the chart notes of December 23, 2013]; and two prescriptions for a Lidocaine patch (a topical anesthetic generally used to treat minor pain) with no detailed description in the chart notes of December 23, 2013, as to why patient C was being prescribed a Lidocaine patch (with one refill).

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[13] At the office visit of December 13, 2012, respondent provided patient C with post-dated prescriptions of Norco 10/325 mg (#120) that were dated January 2, January 22, and February 11, 2013. These prescriptions are not included in the number of prescriptions for 2012, but are included in the number of prescriptions for 2013.

[14] This includes the post-dated prescriptions provided at the office visit of December 13, 2012, but does not include a post-dated prescription dated January 13, 2014, that was provided to patient C during her office visit of December 23, 2013.

25. During the period of on or about January 1, 2014, to December 31, 2014, respondent had three (3) office visits with patient C. According to respondent's progress notes, the visits took place on August 20, October 8, and November 20, 2014. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2014, respondent issued approximately seven (7) prescriptions (which includes one refill) for hydrocodone/APAP (Norco) (#120) (every four hours); three (3) prescriptions (which includes refills) for carisoprodol (Soma) 350 mg (#90) t.i.d. (three a day); and two (2) prescriptions for fentanyl[15] 12 mcg (every 72 hours) (#10) with no explanation in the chart notes of November 20, 2014, as to the justification for prescribing fentanyl (with two refills) to patient C. During 2014, patient C also filled a total of nine (9) other prescriptions for controlled substances (two prescriptions of hydrocodone/APAP (Vicodin) 5/325 mg (#40), three (3) prescriptions of oxycodone/APAP (Percocet) 10/325 mg (#120), one (1) prescription of diazepam (Valium)[16] 5 mg (#24), two (2) prescriptions of fentanyl (Duragesic) 12

[15] Fentanyl transdermal (Duragesic®) patches are a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (c), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated fentanyl transdermal patches are indicated for the management of pain in opioid-tolerant patients, severe enough to require daily, around-the-clock, long term opioid treatment and for which alternative treatment options are inadequate. The FDA has issued several black box warnings about fentanyl transdermal patches including, but not limited to, the risks of addiction, abuse and misuse; life threatening respiratory depression; accidental exposure; neonatal opioid withdrawal syndrome; and the risks associated with the concomitant use with benzodiazepines or other CNS depressants.

[16] Diazepam (Valium®), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders or for the short-term relief of anxiety. Concomitant use of Valium® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Valium®, as a drug of abuse. (Drugs of Abuse, (continued...)

mcg q 48 hours; and one (1) prescription of hydromorphone (Dilaudid)[17] 4 mg (#120) being prescribed by other health care providers, and being filled at different pharmacies, that respondent was unaware of because he was not utilizing risk screening measures, including but not limited to, periodically reviewing CURES.

26. During the period of on or about January 1, 2015, to December 31, 2015, respondent had ten (10) office visits with patient C. According to respondent's progress notes, the visits took place on January 7, March 25, June 25, September 9, October 13, October 28, November 4, November 24, December 1, and December 22, 2015. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2015, respondent issued approximately thirteen (13) prescriptions for hydrocodone/APAP (Norco) (#120) (every four hours); one prescription for hydrocodone/APAP (Norco) (#90) (every four hours); four (4) prescriptions for oxycodone/APAP (Percocet) (#60); one prescription for methylprednisone (Medrol) 4 mg (#21); eight prescriptions for fentanyl (Duragesic) 12 mcg (#10) q 48 hours (one patch every 48 hours); two (2) prescriptions for carisoprodol (Soma) 350 mg (#90) t.i.d. (three a day); nine (9)

(...continued)
DEA Resource Guide (2011 Edition), at p. 53.)

[17] Hydromorphone (Dilaudid®), an opioid analgesic, is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (b), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the treatment of moderate to severe pain. The Drug Enforcement Administration (DEA) has identified hydromorphone, such as Dilaudid®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 37.) The Federal Drug Administration has issued black box warnings for Dilaudid® which warn about, among other things, addiction, abuse and misuse, and the possibility of life-threatening respiratory distress. The warnings also caution about the risks associated with concomitant use of Dilaudid® with benzodiazepines or other central nervous system (CNS) depressants.

prescriptions (which includes refills) for tramadol (Ultram) 50 mg (#90) and prescriptions for various benzodiazepines including, but not limited to, two prescriptions for diazepam (Valium) (#40), six (6) prescriptions (which includes refills) for temazepam 15 mg (#30) and three (3) prescriptions (which includes refills) for alprazolam (Xanax)[18] 1 mg b.i.d. (#40).

27. During the period of on or about January 1, 2016, to April 11, 2016, respondent had three (3) office visits with patient C. According to respondent's progress notes, the visits took place on January 21, February 18, and April 11, 2016. On April 11, 2016, respondent's assessment and plan included "[c]ervical physical therapy 3 days per week" in addition to the controlled substances that he was prescribing for pain and anxiety. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of time in 2016, respondent issued approximately five (5) prescriptions for hydrocodone/APAP (Norco) (#120) (every four hours); eight (8) prescriptions for oxycodone/APAP (Percocet) (#60); four prescriptions (which includes refills) for alprazolam (Xanax) 1 mg b.i.d. (#40); and three (3) prescriptions (which includes refills) for diazepam 10 mg (#40).

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[18] Xanax® (alprazolam), a benzodiazepine, is a centrally acting hypnotic-sedative that is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. When properly prescribed and indicated, it is used for the management of anxiety disorders. Concomitant use of Xanax® with opioids "may result in profound sedation, respiratory depression, coma, and death." The Drug Enforcement Administration (DEA) has identified benzodiazepines, such as Xanax®, as a drug of abuse. (Drugs of Abuse, DEA Resource Guide (2011 Edition), at p. 53.)

28. Respondent committed gross negligence in his care and treatment of patient C which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed controlled substances to patient C without, among other things, obtaining vital signs, considering less risky therapies, conducting appropriate and focused physical examinations, assessing underlying or coexisting conditions, following a treatment plan with measurable stated objectives in regard to pain level and function, conducting meaningful periodic review, seeking consultation, when necessary, and utilizing risk screening measures to identify aberrant behavior and possible diversion of the controlled substances that were being prescribed; and

(b) Respondent failed to maintain complete and adequate medical records concerning his care and treatment of patient C. Respondent's progress notes, among other things, were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed.

PATIENT D

29. According to respondent's certified medical records, respondent first started treating patient D, a then-45-year old male, on or about July 21, 2010. Patient D's self-reported chief complaint was "Back pain [and] Anxiety" that he first noticed in 2005 with no specifics as to whether the back pain was related to an injury. Patient D did not indicate any orthopedic or musculoskeletal problems on his past medical history and review of systems forms but did report

that he was anxious, depressed and had frequent mood swings on his review of systems form. A "Medication Use Agreement" within respondent's certified medical records was signed by patient D, but not respondent. According to respondent's chart note for this visit, patient D was a construction worker with pain that increased in the morning. He was taking 2 to 3 Norco's a day, and had a history of depression and anxiety that he was managing with alprazolam and Prozac. According to respondent, on physical examination, patient D had, among other things, positive cervical and lumbar pain on flexion with full range of motion. Respondent's assessment and plan was to prescribe hydrocodone/APAP (Norco) (#90) q 4 (every four hours) p.r.n. (as needed); continue with alprazolam (Xanax) 2 mg (#40) b.i.d. (twice a day) for anxiety disorder; and Prozac 20 mg (#30) q.d. (one per day) for depression.

30. During the period of on or about July 22, 2010, to December 31, 2010, respondent had five (5) office visits with patient D. According to respondent's progress notes, the visits took place on September 9, September 29, November 10, November 30, and December 17, 2010. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of time in 2010, respondent issued approximately six (6) prescriptions of hydrocodone/APAP (Norco) (#90) (every four hours); five (5) prescriptions of alprazolam (Xanax) 2 mg (#40) (twice a day) and five (5) prescriptions of Prozac 20 mg (#30) (one per day).

31. During the period of on or about January 1, 2011, to December 31, 2011, respondent had twenty-one (21) office visits with patient D. According to respondent's progress notes, the visits took place on January 6, January 24, February 11, February 28, March 18, April 6, April 28, May 16, May 21, June 16, July 1, July 25, August 15, September 1, September 8, September 27, October 17, November 3, November 21, December 9 and December 27, 2011. Respondent's

progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2011, respondent issued approximately nineteen (19) prescriptions for hydrocodone/APAP (Norco) (#90) (every four hours); one (1) prescription of alprazolam (Xanax) 2 mg (#40) (twice a day); ten (10) prescriptions of diazepam (Valium) 10 mg (#40) (twice a day); seven (7) prescriptions (which includes refills) of (fluoxetine) Prozac (generally used to treat depressive and other psychological disorders) 20 mg (#30) (one per day); and one (1) prescription of (fluoxetine) Prozac 40 mg (#60) (two per day) [with no indication in the chart note of September 27, 2011, as to the justification for the increase in the strength and number of Prozac tablets].

32. During the period of on or about January 1, 2012, to December 31, 2012, respondent had twenty-one (21) office visits with patient D. According to respondent's progress notes, the visits took place on January 10, January 30, February 20, March 7, March 26, April 12, May 1, May 16, June 4, June 20, July 12, July 25, August 13, August 29, September 17, October 4, October 22, November 15, November 26, December 14, and December 26, 2012. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2012, respondent issued nine (9) prescriptions for hydrocodone/APAP (Norco) (#90) (every four hours); twelve (12) prescriptions for hydrocodone/APAP (Norco) (#100) (every four hours) [with no indication in the chart note of

June 20, 2012, as to the justification for the increasing the Norco from #90 to #100][19]; one (1) prescription of alprazolam (Xanax) 2 mg (#30) (twice a day); two (2) prescriptions of diazepam (Valium) 10 mg (#40) (twice a day) on March 26 and April 13; and eighteen (18) prescriptions (which includes refills) of Prozac 20 mg (#30) (one per day) on June 20, October 4 and October 22, 2012.[20]

33. During the period of on or about January 1, 2013, to December 31, 2013, respondent had twenty-two (22) office visits with patient D. According to respondent's progress notes, the visits took place on January 14, January 22, February 11, March 4, March 18, April 8, April 30, May 15, June 3, June 18, July 3, July 15, July 29, August 19, September 3, September 24, October 11, October 28, November 14, December 2, December 6, and December 31, 2013. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2013, respondent issued twenty-two (22) prescriptions for hydrocodone/APAP (Norco) (#100) (every four hours).

34. During the period of on or about January 1, 2014, to December 31, 2014, respondent had twenty-one (21) office visits with patient D. According to respondent's progress notes, the visits took place on January 20, February 4, February 24, March 10, March 31, April 14, May 5, May 19, May 27, June 3, June 23, July 14, July 28, August 18, September 2, September 22, October 9, October 29, November 18, December 8, and December 27, 2014. Respondent's

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[19] In fact, respondent's progress notes of June 4, 2012, indicated that patient D was controlled on his current regimen of Norco 10/325 mg (#90) and indicated that he had "[n]o further complaints."

[20] Respondent wrote two prescriptions for Prozac in close proximity with one prescription with six refills written on October 4, 2012, and another prescription with six refills written on October 22, 2012.

progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2014, respondent issued twenty (20) or twenty-one prescriptions[21] for hydrocodone/APAP (Norco) (#100 which was increased to #120) (every four hours) (the first prescription for #120 was on September 2, 2014, with no justification in the progress notes for the increase from #100 to #120.)[22]

35. During the period of on or about January 1, 2015, to December 31, 2015, respondent had nineteen (19) office visits with patient D. According to respondent's progress notes, the visits took place on January 15, February 3, February 21, March 10, March 30, April 17, May 6, May 23, June 11, July 2, July 21, August 11, August 31, September 19, October 9, October 28, November 16, December 4, and December 23, 2015. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2015, respondent issued approximately nineteen (19)

[21] Respondent's chart notes of May 27, 2014 indicate one prescription of hydrocodone/APAP (Norco) was prescribed on this date but there is no corresponding copy of the prescription in respondent's certified medical records.

[22] In fact, respondent's prior progress notes indicated patient D was controlled on his current prescriptions, he reported no new complaints, and the plan was to "continue on same treatment" which included Norco (#120). Moreover, the progress notes for March 31 through July 28, 2014, and September 22, 2014, inaccurately stated Norco (#100) when the actual prescriptions indicate Norco (#120).

prescriptions for hydrocodone/APAP (Norco) (#120) (every four hours).

36. During the period of on or about January 1, 2016, to December 31, 2016, respondent had twenty (20) office visits with patient D. According to respondent's progress notes, the visits took place on January 11, January 30, February 17, March 7, March 24, April 13, May 2, May 19, June 15, June 27, July 6, July 19, August 23, September 7, September 28, October 5, November 10, November 30, December 12, and December 30, 2016. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During 2016, respondent issued approximately ten (10) prescriptions for hydrocodone/APAP (Norco) (#120) (every four hours); and nine (9) prescriptions for hydrocodone/APAP (Norco) (#100) (every four hours) [beginning on July 6, 2016, with no indication in the chart note for the reduction from #120 to #100]. Some of the dates listed in respondent's progress notes as to when the prescriptions were issued do not match the actual dates set forth on the handwritten prescriptions.

37. During the period of on or about January 1, 2017, to May 4, 2017, respondent had seven (7) office visits with patient D. According to respondent's progress notes, the visits took place on January 5,[23] January 18, February 6, March 2, March 30, April 25, and May 4, 2017. Respondent's progress notes during this time were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions,

[23] According to respondent's chart notes, respondent prescribed four hundred (#400) hydrocodone/APAP (Norco) 10/325 mg for November 30, 2016, through January 7, 2017.

including, but not limited to, any treatment plan and justification for the prolonged use of the controlled substances that were being prescribed. During this period of 2017, respondent issued approximately seven (7) prescriptions for hydrocodone/APAP (Norco) (#100) (every four hours). There was overlap in some of the prescriptions written by respondent.[24]

38. Respondent committed gross negligence in his care and treatment of patient B which included, but was not limited to, the following:

(a) Respondent repeatedly prescribed controlled substances to patient D without, among other things, obtaining vital signs, considering less risky therapies, conducting appropriate and focused physical examinations, assessing underlying or coexisting conditions, following a treatment plan with measurable stated objectives in regard to pain level and function, conducting meaningful periodic review, seeking consultation, when necessary, and utilizing risk screening measures to identify aberrant behavior and possible diversion of the controlled substances that were being prescribed; and

(b) Respondent failed to maintain complete and adequate medical records concerning his care and treatment of patient D. Respondent's progress notes, among other things, were cursory, lacked adequate detail, failed to set forth any specific goals of treatment including other possible treatment options besides controlled substances, efficacy and/or functional improvement; failed to document, among other things, vital signs, focused physical examinations, informed consent, proper consultation, when warranted, and/or risk screening measures; and failed to provide a clear rationale for any medical decisions, including, but not limited to, any

[24] As an example, respondent's progress notes for December 30, 2016, indicate he wrote one prescription for Norco (#100) that was not to be filled until January 8, 2017. Respondent's subsequent progress notes of January 5, 2017, indicated he wrote another prescription for Norco (#100) that was not to be filled until January 7, 2017. In doing so, he effectively gave patient D two prescriptions for Norco (#100) that could both be filled on January 8, 2017, or shortly thereafter.

treatment plan and justification for the prolonged use of the controlled substances that were being prescribed.

SECOND CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

39. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (c), of the Code, in that he committed repeated negligent acts in his care and treatment of patients A, B, C, and D, as more particularly alleged in paragraphs 7 through 38, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

40. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2234, subdivision (d), of the Code, in that he has demonstrated incompetence in his care and treatment of patient A, B, C and D, as more particularly alleged in paragraphs 7 through 38, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

FOURTH CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Medical Record)

41. Respondent is further subject to disciplinary action under sections 2227 and 2234, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in his care and treatment of patients A, B, C and D, as more particularly alleged in paragraphs 7 through 38, above, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Medical Board of California issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate No. A 85653, issued to respondent Richard Dieter Ruth, M.D.;

2. Revoking, suspending or denying approval of respondent Richard Dieter Ruth, M.D.'s authority to supervise physician assistants and advanced practice nurses;

3. Ordering respondent Richard Dieter Ruth, M.D., if placed on probation, to pay the Board the costs of probation monitoring; and

4. Taking such other and further action as deemed necessary and proper.

DATED: July 6, 2018

KIMBERLY KIRCHMEYER
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
Complainant

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